U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 31 March 2003

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In the Matter of:

WOODROW K. ADAIR,
Claimant

Case No.: 2001-BLA-1078

v.

CONSOLIDATION COAL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party In Interest
.....

Appearances:

Kendrick King, Esq.
Welch, West Virginia
For the Claimant

Ann Rembrandt, Esq.
Jackson & Kelly, PLLC
Charleston, West Virginia
For the Employer

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et seq. The Act and implementing regulations, 20 CFR Parts 410, 718, 725 and 727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR §

718.201 (2002). In this case, the Claimant, Woodrow K. Adair, alleges that he is totally disabled by pneumoconiosis.

I conducted a hearing on this claim on January 29, 2002, in Bluefield, West Virginia. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2002). At the hearing, Director's Exhibits ("DX") 1-27, and Employer's Exhibits ("EX") 1-18 were admitted into evidence without objection. Transcript ("Tr.") at 7, 9. The record was held open after the hearing to allow the parties to submit closing arguments. Claimant's brief was received March 6, 2002, and Employer's brief was received March 5, 2002.

In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all exhibits, the testimony at hearing and the arguments of the parties.

PROCEDURAL HISTORY

The Claimant filed his initial claim on October 18, 1979. DX 25-1. The claim was denied by the Director of the Office of Workers' Compensation Programs (the "Director," "OWCP") on August 15, 1980, on the grounds that the evidence did not show that the Claimant had pneumoconiosis, nor that it was caused by coal mine work, nor that the Claimant was totally disabled due to the disease. DX 25-11. The Claimant did not appeal that determination.

More than one year later, the Claimant filed a duplicate claim on May 31, 2000. DX 1. The duplicate claim was denied by the Director, OWCP on November 21, 2000. DX 12. Claimant requested a hearing on January 5, 2001, DX 14, and filed additional evidence on January 16, 2001. DX 15. On March 29, 2001, the OWCP denied the claim after considering the additional evidence. DX 16. Claimant again requested a hearing on April 24, 2001. DX 17. The claim was referred to the Office of Administrative Law Judges for hearing on August 2, 2001. DX 26.

ISSUES

The issues contested by the Employer and the Director are:

1. Whether the claim was timely filed.

2. How long Mr. Adair worked as a miner.

3. Whether Mr. Adair has pneumoconiosis as defined by the Act and the regulations.

4. Whether his pneumoconiosis arose out of coal mine employment.

5. Whether he is totally disabled.

6. Whether his disability is due to pneumoconiosis.

7. The number of his dependents for purposes of augmentation.

8. Whether the named Employer is the Responsible Operator.

9. Whether the evidence establishes a material change in conditions pursuant to 20 CFR § 725.309 (2000).

DX 26; Employer's Pre-Hearing Statement; Tr. at 6.

APPLICABLE STANDARDS

This claim relates to a "duplicate" claim filed on May 31, 2000. Because the claim at issue was filed after March 31, 1980, the regulations at 20 CFR Part 718 apply. 20 CFR § 718.2 (2002). Parts 718 (standards for award of benefits) and 725 (procedures) of the regulations have undergone extensive revisions effective January 19, 2001. 65 Fed. Reg. 79920 et seq. (2000). The Department of Labor has taken the position that as a general rule, the revisions to Part 718 should apply to pending cases because they do not announce new rules, but rather clarify or codify existing policy. *See* 65 Fed. Reg. at 79949-79950, 79955-79956 (2000). Changes in the standards for administration of clinical tests and examinations, however, would not apply to medical evidence developed before January 19, 2001. 20 CFR § 718.101(b) (2002). The new rules specifically provide that some revisions to Part 725 apply to pending cases, while others (including revisions to the rule regarding duplicate claims) do not; for a list of the revised sections which do **not** apply to pending cases, see 20 CFR § 725.2(c) (2002). The U.S. District Court for the District of Columbia upheld the validity of the new regulations in *National Mining Association v. Chao*, 160 F.Supp.2d 47 (D.D.C. 2001). However, the Court of Appeals affirmed in part, reversed in part, and remanded the case. *National Mining Association v. Department of Labor*, 292 F.3d 849 (D.C. Cir. 2002) (Upholding most of the revised rules, finding some could be applied to pending cases, while others should be applied only prospectively, and holding that one rule empowering cost shifting from a Claimant to an employer exceeded the authority of the Department of Labor). Accordingly, I will apply only the sections of the newly revised version of Parts 718 and 725 that the court did not find impermissibly retroactive. In this Decision and Order, the "old" rules applicable to this case will be cited to the 2000 edition of the Code of Federal Regulations; the "new" rules will be cited to the 2002 edition.

Pursuant to 20 CFR § 725.309 (2000), in order to establish that he is entitled to benefits in connection with his duplicate claim, Mr. Adair must demonstrate that there has been a "material change in conditions" since the denial of his previous claim such that he now meets the requirements for entitlement to benefits under 20 CFR Part 718. In order to establish entitlement to benefits under Part 718, he must establish that he suffers from pneumoconiosis, that his

pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 CFR §§ 718.1, 718.202, 718.203 and 718.204 (2002). I must consider the new evidence and determine whether Mr. Adair has proved at least one of the elements of entitlement previously decided against him. If so, then I must consider whether all of the evidence establishes that he is entitled to benefits. *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358 (4th Cir. 1996). Because I find that he has established a material change in conditions, the medical evidence from his initial claim will be addressed in this decision and order where appropriate .

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

Mr. Adair testified that he was 57 years old a the time of the hearing. Tr. at 11; DX 5. He is married to Deloris Adair, whom he wed on August 6, 1965. Tr. at 19. She is his only dependent. Tr. at 19. The Claimant testified that he has smoked for approximately forty years. Tr. at 29. However, when he worked long hours for Bishop Coal Company, he didn't have much time to smoke. Tr. at 30.

Mr. Adair's last coal mine employment was in West Virginia. DX 2. Therefore this claim is governed by the law of the Fourth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc). He testified that he began coal mining in 1961, but worked only a short time loading coal by hand. Tr. at 12. In 1967, he began work for Bishop Coal Company, and continued to work there until 1975. Tr. at 12. He was a welder and a cutter who was exposed to welding and coal mine fumes. This job lasted three months until he was moved to an underground job. In that capacity, he worked ten- to fourteen-hour shifts operating a continuous miner, a shuttle car, and a roof bolting machine. Tr. at 14. He was exposed to coal dust during this time. Tr. at 12-13. Mr. Adair eventually became a section foreman for Bishop Coal Company, a subsidiary of Consolidation Coal Company, but performed the same jobs just enumerated. Tr. at 14. He usually worked six days a week. The work involved a lot of manual labor and, according to the Claimant, the long walls where he sometimes worked were, in his opinion, usually out of compliance, and, as a result, extremely dusty. Tr. at 15, 17, 38.

The Claimant then worked for the U.S. government as a federal coal mine health and safety inspector. It was a forty-hour-a-week job. Tr. at 16. Mr. Adair inspected the entire operation, including preparation plants, loading areas, haulage areas, all the return airways, and the longwall faces. He described the return airways as especially dusty. Later on, he was fitted for a respirator. Tr. at 17. Mr. Adair worked for the government for over 22 years. Tr. at 25.

Mr. Adair also described his work for Corbin Coal Company as a stock person. He cleaned belts and shoveled the belts on the outside. Tr. at 18. This was very dusty work and only lasted one month. Tr. at 27.

The Claimant stated that besides coal mine dust exposure, he was also exposed to toxic

gases from welding and fires. Tr. at 18. Mr. Adair testified that he could not return to any of his coal mining jobs. Tr. at 32-33. He becomes short of breath after very little exertion and develops chest pains. Tr. at 33.

Dependents

Based on the Claimant's testimony, I find that he has one dependent–his wife, Deloris–for purposes of augmentation of benefits.

Timeliness

The purpose of the Regulation allowing the filing of duplicate claims is "to provide relief from the ordinary principles of finality and res judicata to miners whose physical condition deteriorates." *Lukman v. Director, OWCP*, 896 F.2d 1248, 1253 (10th Cir. 1990). There is no statute of limitations or time limit for filing a duplicate claim. 20 CFR § 725.309 (2000); *Andryka v. Rochester Pittsburgh Coal Co.*, 14 B.L.R. 1-34 (1990). The Employer has offered no evidence or argument in support of this issue, except for an assertion that the claim must be denied "if the Court finds that the Claimant is entitled to federal black lung benefits, and relies upon any evidence . . . which precedes May 1997," three years before the duplicate claim was filed. Employer's Closing Argument at 3; *see* 30 U.S.C. § 932(f); 20 CFR § 308. I find that the claim is timely.

Length of Employment as a Miner

According to the employment histories, the Claimant submitted to the Department of Labor and Social Security records, the Claimant began working in the mines in 1967. He left the mines in 1998. DX 4. A letter from Consolidation Coal Company's Benefits and Compensation manager states that Mr. Adair worked for Bishop Coal Company as a mechanic from August 21, 1967 to November 30, 1973, and as a section foreman from December 1, 1973 to November 14, 1975. DX 3. This totals eight years and three months. The Social Security records confirm this employment. DX 4. He also worked for one month at Corbin Coal in 1999. Tr. at 27; DX 15.

The Social Security records also confirm sixteen years of employment as a federal mine inspector from 1983 through 1998. The Claimant argued that Mr. Adair should be credited for his time as an inspector. *See* Claimant's Closing Argument. Mr. Adair testified that he inspected the entire mining operation, including the preparation plants, loading and haulage areas, return airways, and longwall faces. Tr. at 16. An individual need not have been engaged in the actual extracting or preparing of coal to meet the function test so long as the work he performed was integral to the coal production process. *Ray v. Williamson Shaft Contracting Co.*, 14 BLR 1-105 (1990). The Benefits Review Board has held that a federal mine inspector is a miner within the meaning of the Act since his work concerned health and safety which is integral to the operation of a coal mine. *Moore v. Duquesne Light Co.*, 4 BLR 1-40.2, 1-44 (1981). *But see Falcon Coal Co. v. Clemons*, 873 F.2d 916 (6th Cir. 1989) (if a worker's tasks are merely convenient, but not

vital or essential to the production or extraction of coal, he is generally not classified as a miner; night watchman not a miner). I find that Mr. Adair's job as inspector was integral to the extraction or preparation of coal inasmuch as his inspections either allowed the mine to continue to operate or could have closed it down. Consequently, I consider his work for the U.S. government to constitute coal mine employment. Thus, I find that the Claimant had twenty-four years and four months of coal mine employment.

Responsible Operator

The Claimant testified that he worked at Bishop Coal Company, a subsidiary of Consolidation Coal Company, from 1967 until 1975, when he went to work for the U.S. Department of Labor, Mine Safety and Health Administration. Tr. at 12, 16. The Director found that the Claimant worked for Consolidation Coal Company from 1967 to 1975, verified by Social Security records, and identified Consolidation as the responsible operator. DX 21. The Employer stipulated at the hearing that the Claimant was employed by it for eight years. Tr. at 6. However, it argued that if Mr. Adair is credited with his time as a coal mine inspector, then the U.S. Department of Labor, Mine Safety and Health Administration should be deemed responsible operator. *See* Employer's Closing Argument. In *Moore*, 4 BLR at 1-44–1-47, however, the BRB considered that issue at length, and determined that the federal government cannot be a responsible operator because it is not capable of assuming liability.[1] There is no evidence that Consolidation Coal Company is unable to assume liability in the event the Claimant is found to be eligible for benefits. I therefore find that the evidence supports that Consolidation Coal Company, which was self insured during the relevant time period, is the properly designated responsible operator pursuant to 20 CFR §§ 725.491, 492 and 493. DX 18.

Material Change in Conditions

In a duplicate claim, the threshold issue is whether there has been a material change in conditions As will be discussed in more detail below, medical reports indicate that Mr. Adair now has a pulmonary impairment which is totally disabling. This constitutes a material change in conditions. Because the new evidence establishes that a material change in conditions has occurred, I must consider all of the evidence in the record in reaching my decision whether he is now entitled to benefits. *Lisa Lee Mines v. Director, OWCP*, 57 F.3d 402, 406 (4th Cir. 1995).

Medical Evidence

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The quality standards for chest x-rays and their interpretations performed before January 19, 2001, are found

[1]That principle has now been added to the new regulations, 20 CFR § 725.491(f) (2002).

at 20 CFR § 718.102 (2000) and Appendix A of Part 718. The following table summarizes the x-ray findings available in this case. The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2000). All such readings are therefore included in the "negative" column. X-ray interpretations which make no reference to pneumoconiosis, positive or negative, generally given in connection with medical treatment for other conditions, are listed in the "silent" column.

Physicians' qualifications appear after their names. Qualifications have been obtained where shown in the record by curriculum vitae or other representations. If no qualifications are noted for any of the following physicians, it means that I have been unable to ascertain them from the record. Qualifications of physicians are abbreviated as follows: B= NIOSH certified B-reader; BCR= board-certified in radiology. Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B-readers need not be radiologists.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis
11/28/73		EX 3 Dennis/B 0/0 EX 3 Wheeler/BCR, B 0/-
08/18/75	DX 15 Scott 1/1; p; 6 zones	
10/05/78	DX 15 Aycoth/BCR, B 1/2; p	
05/12/80	DX 15-8 Unknown 1/1; p	DX 25-10 Smith/BCR, B 0/0
04/21/87		EX 3 Rosenstein/BCR, B Completely negative EX 3 Donlan/BCR, B Completely negative EX 3 Harrison/BCR, B Completely negative
06/02/92	DX 15 Salen Mild coal workers' pneumoconiosis	
07/11/95	DX 15 Salen Minimal coal workers' pneumoconiosis	

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis
03/06/96		EX 5 Lapp/B Negative EX 5 Wang/B No evidence of coal workers' pneumoconiosis
10/12/99	DX 15 Subramaniam/B 1/1; p/s	EX 2 Wiot/BCR, B No evidence of coal workers' pneumoconiosis EX 7 Spitz/BCR, B No evidence of coal workers' pneumoconiosis EX 13 Castle/B 0/1; t/s; 2 zones
08/28/00	DX 9 Patel/BCR, B 1/0; s/p; 6 zones	DX 10 Ranavaya/B 0/1 DX 11 Binns/BCR, B 0/1 EX 1 Wheeler/BCR, B No evidence of coal workers' pneumoconiosis; emphysema EX 1 Scott/BCR, B No evidence of coal workers' pneumoconiosis; emphysema EX 1 Kim/BCR, B No evidence of coal workers' pneumoconiosis; emphysema
01/30/01	DX 17 Cappiello/BCR, B 2/1	EX 2 Wiot/BCR, B No evidence of coal workers' pneumoconiosis EX 7 Spitz/BCR, B No evidence of coal workers' pneumoconiosis EX 13 Castle/B 0/1; t/s; 2 zones
10/29/01		EX 4 Castle/B 0/1; t/s; 2 zones EX 8 Wheeler/BCR, B No evidence of coal workers' pneumoconiosis; emphysema EX 8 Scott/BCR, B No evidence of coal workers' pneumoconiosis; bullous emphysema EX 10 Kim/BCR, B No evidence of coal workers' pneumoconiosis; bullous emphysema

CT Scans

CT scans may be used to diagnose pneumoconiosis and other pulmonary diseases. The regulations provide no guidance for the evaluation of CT scans. They are not subject to the

specific requirements for evaluation of x-rays, and must be weighed with other acceptable medical evidence. *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31, 1-33-1-34 (1991). The record in this case contains two reports of one CT scan of Mr. Adair's chest.

Exhibit Number	Date of CT	Reading Physician	Interpretation or Impression
DX 15	07/21/95	ALOSH	Small amount of black lung present; some emphysema
EX 9, 17 @ 12	07/21/95	Renn/B	No changes consistent with pneumoconiosis; bullous emphysema

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV). The quality standards for pulmonary function studies performed before January 19, 2001, are found at 20 CFR § 718.103 (2000) and Appendix B. The following chart summarizes the results of the pulmonary function studies available in this case. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.203(b)(2)(i) (2002).

Ex. No. Date Physician	Age Height	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
EX 3 11/28/73 ALOSH	28 69"	4.03	4.85	83%		No	Drs. Castle and Renn said there are no tracings with which to validate this study. EX 4, 14. Dr. Renn also said ventilatory function was normal. EX 17 @ 20.
DX 25-7 05/12/80 Hatfield	35 69"	2.754	3.564	70.6%	105.3	No	Mild obstructive disease. Excellent effort. Dr. Castle found invalid because of inadequate exhalation time and obstruction of the mouthpiece. EX 4. Dr. Renn found poor cooperative effort. EX 17 @ 20.
EX 3 04/21/87 ALOSH	42	3.22	4.08	79%	–	No	Normal spirometry. Dr. Renn said no tracings available to determine validity. EX 17 @ 26.

Ex. No. Date Physician	Age Height	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
EX 5 07/21/95 ALOSH	50 70"	2.89 2.96	3.90 4.04	73% 73%	– –	No No	Normal. Drs. Renn and Rosenberg also found within normal limits. EX 9, 17. Dr. Castle found invalid due to 2, rather than 3, test procedures. EX 18 @ 19-20.
DX 15 10/12/99 Tug River Health Ass'n	54 69"[2]	1.85 1.84	2.75 2.98	67% 62%	– –	No No	Effort considered fair by Dr. Renn. EX 9, 17

[2]The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance of one inch in the recorded height of the miner, I have taken the average height (69.5") in determining whether the studies qualify to show disability under the regulations. Only one of the tests is qualifying to show disability, whether considering the average height or the heights listed by the physicians who administered the testing.

Ex. No. Date Physician	Age Height	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 6 08/28/00 Rasmussen	55 69"	2.22 2.64	3.68 4.25	60% 62%	69 99	No No	Minimal, partially reversible obstructive ventilatory impairment. Dr. Renn found significant bronchoreversibility EX 17 @ 22. Dr. Castle found the study valid with significant reversibility, indicating an asthmatic component. EX 18 @ 20.
EX 4 10/29/01 Castle	56 70"	1.55 1.58	2.64 2.78	59% 57%	48 _	Yes No	The diffusing capacity is only mildly reduced after correction for alveolar volume. No restriction. Dr. Renn found the study valid, showing severe obstructive airway disease. EX 17 @ 21.

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (PO_2) and the percentage of carbon dioxide (PCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled. The quality standards for arterial blood gas studies performed before

January 19, 2001, are found at 20 CFR § 718.105 (2000). The following chart summarizes the arterial blood gas studies available in this case. A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b) (2000).

Exhibit Number	Date	Physician	PCO_2 at rest/ exercise	PO_2 at rest/ exercise	Qualify?	Physician Impression
DX 25-9	05/12/80	Hatfield	32.1	89	No	
DX 15	10/12/99	Leacock	37	75	No	Dr. Renn found normal for age. EX 14
DX 8	08/28/00	Rasmussen	33 34	71 73	No No	Minimal to moderate impairment in oxygen transfer. DX 7. Dr. Renn found normal for age. EX 14
EX 4	10/29/01	Castle	39.7	65.7	No	Very mild hypoxemia. Dr. Renn found normal for age. EX 14.

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2002). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2002). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be

nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv) (2002). With certain specified exceptions, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2002). Quality standards for reports of physical examinations performed before January 19, 2001, are found at 20 CFR § 718.104 (2000). The record contains the following medical opinions.

Mr. Adair was examined by Dr. J.R. Hatfield on behalf of the Director on May 12, 1980. DX 25-8. He took occupational, smoking, and medical histories, conducted a physical examination, and administered chest x-ray, blood gas and pulmonary function testing. Dr. Hatfield diagnosed pneumoconiosis and a mild respiratory impairment.

The record contains a report dated October 30, 1995 from the Department of Health and Human Services. DX 16. Only two pages of the report are in the record, and reviewing physicians note that the author is a Dr. Petsonk, although this cannot be verified by the record itself. The letter informs Mr. Adair of the purpose of the studies he underwent and their outcomes. Standard breathing tests showed normal lung function. A bronchodilator test revealed a reversible airway obstruction. The diffusing capacity test showed that Mr. Adair's lungs' ability to take up oxygen was below normal. An airway resistance test was also normal.

Dr. D. L. Rasmussen examined Mr. Adair on behalf of the Director on August 28, 2000. DX 7. Dr. Rasmussen is board certified in internal medicine. He took occupational, smoking, and medical histories, conducted a physical examination, and administered chest x-ray, blood gas, and pulmonary function testing. He concluded that Mr. Adair has coal workers' pneumoconiosis due to thirty years of coal mine dust exposure; chronic obstructive pulmonary disease/emphysema due to coal mine dust exposure and cigarette smoking; and possible asthma due to a non-occupational cause. Dr. Rasmussen opined that Mr. Adair had at least minimal loss of lung function and was unable to perform very heavy manual labor. He attributed the miner's disability to cigarette smoking, coal mine dust exposure, and possible asthma but stressed that the coal mine dust exposure was a significant contributing factor.

Dr. James R. Castle examined Mr. Adair on behalf of the Employer on November 7, 2001. EX 4. Dr. Castle is board-certified in internal medicine and pulmonary disease. He took occupational, smoking, and medical histories, conducted a physical examination, and administered chest x-ray, blood gas and pulmonary function testing. Dr. Castle concluded that there was no evidence of coal workers' pneumoconiosis. He diagnosed chronic obstructive pulmonary disease and chronic bronchitis, both of which he felt were induced by tobacco smoke. Dr. Castle also found a moderate chronic airway obstruction which he believed was secondary to the COPD and chronic bronchitis. Dr. Castle also reviewed other medical data, including x-rays reports from 1973, 1975, 1978, 1980, 1992, 1995, 1999, 2000, and 2001, the CT scan reports, blood gas

studies, pulmonary function studies, and the medical report of Drs. Hatfield. The additional medical evidence did not cause him to change his opinions. He noted there were no physical findings consistent with pneumoconiosis, such as rales, crackles, or crepitations. A significant degree of reversibility after bronchodilator administration was consistent with tobacco smoke-induced bronchitis, rather than pneumoconiosis. Dr. Castle further opined that Mr. Adair is totally disabled from performing coal mining jobs but attributed the disability to tobacco smoke-induced asthmatic bronchitis and chronic airway obstruction, not coal mine employment. Even assuming the existence of pneumoconiosis, Dr. Castle still averred that the disease would not have caused disability.

Dr. Castle reviewed additional evidence on December 19, 2001. EX 12. He considered his own report as well as those of Drs. Petsonk and Rasmussen, and the 1999 and 2001 x-ray readings by Dr. Spitz. Dr. Castle stated that the additional evidence did not cause his opinion to change.

Dr. Castle was deposed on January 22, 2002. EX 18. He provided his credentials and additionally reviewed Dr. Kim's x-ray reading, Dr. Renn's CT scan reading and two medical reports, the reports of Drs. Rosenberg and Morgan, and the most recent x-rays. He further explained his opinion that the medical evidence does not indicate the existence of pneumoconiosis. Rather, he explained, asthma is a bronchoreversible condition that waxes and wanes over time. He also stated that the Miner's diffusion capacity was consistent with tobacco smoke-induced pulmonary emphysema. Finally, he reiterated that Mr. Adair is totally disabled by his pulmonary emphysema and asthma.

Dr. David M. Rosenberg reviewed Mr. Adair's medical records on behalf of the Employer on December 17, 2001 and provided a report of the same date. EX 11. Dr. Rosenberg is board-certified in internal medicine and pulmonary disease. He received the medical reports of Drs. Hatfield, Petsonk, Rasmussen, and Castle, and the Tug River Health Association, x-ray interpretations dating back to 1973, pulmonary function studies, and blood gas studies. Dr. Rosenberg opined that Mr. Adair does not have pneumoconiosis. He based his opinion on the x-ray results, the lack of evidence of a restrictive lung disease, and no rales on physical examination. He diagnosed chronic obstructive pulmonary disease due to smoking, resulting in significant impairment. In fact, Dr. Rosenberg opined that Mr. Adair is totally disabled from returning to coal mine employment due to his smoking and unrelated to his coal mine employment. He added that even if the Claimant were found to have pneumoconiosis, his opinion on disability causation would not change.

Dr. Joseph J. Renn, III, reviewed Mr. Adair's medical records on behalf of the Employer on December 22, 2001. EX 14. Dr. Renn is board certified in internal medicine and pulmonary disease. He reviewed the same data that Dr. Rosenberg did and also opined that Mr. Adair does not suffer from pneumoconiosis. He diagnosed chronic bronchitis and bullous emphysema due to tobacco smoking and possible allergic asthma. Dr. Renn noted a severe, occasionally bronchoreversible obstructive ventilatory defect that was not due to coal mine dust exposure.

Rather, Dr. Renn asserted that Mr. Adair is totally disabled from a respiratory standpoint due to tobacco smoke with possible contribution of atopic asthma.

Dr. Renn was deposed on January 17, 2002. EX 17. He provided his credentials and reviewed his CT scan interpretation. He explained that Mr. Adair's bullous emphysema is a progression of centrilobular emphysema caused by tobacco smoking that worsened into panlobular emphysema that evolved into bullous emphysema. Dr. Renn considered Mr. Adair's significant exposure to coal mine dust and testified that his decreased breath sounds were consistent with emphysema. After reviewing his findings of the pulmonary function studies, he opined that the significant bronchoreversibility shown on the August 2000 study was not consistent with pneumoconiosis, but rather with smoke-induced lung disease. Lastly, Dr. Renn stated that Mr. Adair could not perform his prior heavy manual labor required of his coal mine employment, based on the October 2001 pulmonary function study.

Dr. W.K.C. Morgan reviewed Mr. Adair's medical records on behalf of the Employer on January 3, 2002. EX 15. Dr. Morgan reviewed x-ray readings dating back to 1973, pulmonary function studies, blood gas studies, and the medical reports of Drs. Petsonk and Castle. He found no objective evidence of pneumoconiosis but did diagnose asthma. In his opinion, Mr. Adair has mild to moderate obstructive pulmonary impairment due to cigarette smoking. Dr. Morgan concluded that the miner is not totally disabled. He added that even if Mr. Adair were found to have pneumoconiosis, he has no impairment due to the disease.

Total Disability

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 CFR § 718.304 (2002), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 CFR § 718.204(b) and (c) (2002). The regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and (5) lay testimony. 20 CFR § 718.204(b) and (d) (2002). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 CFR § 718.204(d) (2002); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). There is no evidence in the record that Mr. Adair suffers from complicated pneumoconiosis or cor pulmonale. Thus I will consider pulmonary function studies, blood gas studies and medical opinions.

There are six pulmonary function studies in the record. I must determine the reliability of a study based upon its conformity to the applicable quality standards, *Robinette v. Director, OWCP*, 9 B.L.R. 1-154 (1986), and must consider medical opinions of record regarding reliability of a particular study. *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131, 1-133–134 (1986). Little or

no weight may be accorded to a ventilatory study if the miner exhibited "poor" cooperation or comprehension. *Houchin v. Old Ben Coal Co.*, 6 B.L.R. 1-1141 (1984); *Runco v. Director, OWCP*, 6 B.L.R. 1-945, 1-946–947 (1984); *Justice v. Jewell Ridge Coal Co.*, 3 B.L.R. 1-547, 1-551 (1981).

The November 28, 1973 study did not result in qualifying values. Both Dr. Castle and Dr. Renn observed that there are no tracings with which to validate this study. Nonetheless, Dr. Renn said that ventilatory function was normal in this study.

The May 12, 1980 study also did not result in qualifying values. Although Dr. Hatfield found mild obstructive disease and recorded excellent effort, Dr. Renn found poor cooperative effort, and Dr. Castle found the study invalid because of inadequate exhalation time and obstruction of the mouthpiece.

The July 21, 1995 study did not yield qualifying values. Drs. Renn and Rosenberg reviewed the test and found that it produced normal values.

The October 12, 1999 study likewise did not produce qualifying values. Dr. Renn reviewed the study and commented that the Claimant gave fair effort.

The August 28, 2000 pulmonary function test produced non-qualifying values. In reviewing the study, Dr. Renn commented that it evinced significant bronchoreversibility. Dr. Castle echoed this conclusion, adding that such reversibility indicates an asthmatic component. He further found the study valid.

The final study of record, dated October 29, 2001, produced qualifying values pre-bronchodilator. However, the post-bronchodilator test did not yield qualifying values. Dr. Renn considered this study valid upon his review of it.

Of the six studies, of which the four most recent include both pre- and post-bronchodilator tests, only the most recent pre-bronchodilator study produced qualifying values. It was independently judged valid by Dr. Renn. This study, when compared with the August 2000 test, clearly shows a worsening of pulmonary ability. However, the post-bronchodilator study did not yield qualifying values, and the majority of studies did not either. Therefore, while there is some evidence of total disability, I find that the pulmonary function study evidence fails to establish, by a preponderance of the evidence, total disability pursuant to § 718.204(b)(2)(i).

None of the four blood gas studies, dated May 12, 1980, October 12, 1999, August 28, 2000, and October 29, 2001, produced qualifying values. Consequently, I find that the blood gas study evidence does not establish total disability pursuant to § 718.204(b)(2)(ii).

Dr. Hatfield found only a mild impairment in May 1980, which formed the basis for denial of the Claimant's initial claim. In August 2000, Dr. Rasmussen felt that the Claimant was unable

to perform heavy manual labor. By November 2001, Dr. Castle opined that Mr. Adair was totally disabled from performing his last coal mining job. Dr. Rosenberg also found Mr. Adair totally disabled from returning to coal mine employment. Dr. Renn asserted that the Claimant is totally disabled from a respiratory standpoint. Only Dr. Morgan opined that while Mr. Adair has a mild to moderate pulmonary impairment, he is not totally disabled.

Drs. Castle, Rosenberg and Renn were hired by the Employer, and for this reason I find their opinions in favor of total disability particularly probative. Dr. Castle was the only one of the four physicians who actually examined Mr. Adair. He also reviewed all the medical evidence of record, including an in-depth review of the pulmonary function studies. Therefore, I place greater weight on his opinion. The opinions of Drs. Rosenberg and Renn are also entitled to great weight because of their credentials and their thorough reviews of the medical evidence. By comparison, Dr. Morgan did not review as much medical data, and his credentials do not appear of record. Dr. Rasmussen's opinion strengthens those of Drs. Castle, Rosenberg, and Renn. For these reasons, I find that the evidence establishes total disability pursuant to § 718.204(b)(2)(iv).

Upon consideration of all the medical evidence under § 718.204(b)(2), I find the medical opinion evidence to be the most probative. It is further bolstered by the chronological worsening of pulmonary condition elicited by the pulmonary function studies. As a consequence, I find that Mr. Adair has established total disability pursuant to § 718.204(b)(2).

With the establishment of total disability, the Claimant has also established a material change in condition since the August 15, 1980 denial of benefits. Therefore, I will now examine all the medical evidence of record to determine whether Mr. Adair can establish the existence of pneumoconiosis and that his total disability is due to pneumoconiosis.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.
>
> (1) *Clinical Pneumoconiosis.* "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, *i.e.*, the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.

(2) *Legal Pneumoconiosis.* "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2002). In this case, Mr. Adair's medical records indicate that he has been diagnosed with chronic obstructive pulmonary disease and emphysema, which can be encompassed within the definition of legal pneumoconiosis. Ibid.; *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995).

20 CFR § 718.202(a) (2002), provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in §§ 718.304 (irrebuttable presumption of total disability due to pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982) or 718.306 (applicable only to deceased miners who died on or before March 1, 1978), or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no evidence that Mr. Adair has had a lung biopsy, and, of course, no autopsy has been performed. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions. Absent contrary evidence, evidence relevant to either category may establish the existence of pneumoconiosis. In the face of conflicting evidence, however, I must weigh all of the evidence together in reaching my finding whether the Claimant has established that he has pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000); *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22 (3rd Cir. 1997).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. *See Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn*

Coal Corp., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co.*, 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

There are 30 readings of 12 separate x-rays in this case, and 8 have been read by some but not all reviewers to be positive for pneumoconiosis, while 4 have been read only to be negative. For cases with conflicting x-ray evidence, the regulations specifically provide,

> Where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

20 CFR § 718.202(a)(1) (2002); *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31, 1-37 (1991). Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually qualified physicians. *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128, 1-131 (1984). A judge may consider the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. *Woodward*, 991 F.2d at 321; *see Adkins*, 958 F.2d at 52.

The November 28, 1973 x-ray was found negative by Dr. Dennis, a B-reader, and Dr. Wheeler, a dually qualified physician. Accordingly, I find this x-ray to be negative for pneumoconiosis.

The August 18, 1975 x-ray was found positive by Dr. Scott and was not reread. Similarly, the October 5, 1978 x-ray was found positive by Dr. Aycoth, a dually certified reader. It was not reread. Because there is no conflicting evidence, I consider both these x-rays positive for pneumoconiosis.

The May 12, 1980 x-ray was found negative by Dr. Smith, a dually certified reader. Dr. Hatfield's report, DX 25-8, suggests that he (or someone else) found it positive, but the reading itself is not in the file, so the identity and qualifications of the reader are unknown. I find this x-ray to be negative for pneumoconiosis.

The x-ray taken on April 21, 1987 has been read as completely negative by Drs. Rosenstein, Donlan, and Harrison, all of whom are dually qualified physicians, that is, board certified in radiology and B-readers. Consequently, I find that this x-ray is negative for

pneumoconiosis.

The June 2, 1992 and July 11, 1995 x-rays were read as positive by Dr. Salen, who, according to the record, has no particular qualifications for x-ray interpretation. However, because these films were not reread, I find them to be positive for pneumoconiosis.

The March 6, 1996 x-ray was found negative by Drs. Lapp and Wang. I find it negative.

The October 12, 1999 x-ray was found positive by Dr. Subramaniam, a B-reader. It was reread as negative by Drs. Lapp, Wang, and Castle, all of whom are also B-readers, as well as by Drs. Wiot and Spitz, who are dually certified. Because the two most highly qualified readers found the film negative, I defer to their opinions and consider this x-ray to be negative for pneumoconiosis.

The August 28, 2000 x-ray was found positive by Dr. Patel, a dually certified reader. It was reread as negative by Dr. Ranavaya, a B-reader, as well as by Drs. Binns, Wheeler, Scott, and Kim, all of whom are dually certified. Although Dr. Patel's credentials are equivalent to those of Drs. Binns, Wheeler, Scott, and Kim, I am persuaded by the number of negative readings in this instance. Consequently, I consider this x-ray negative for pneumoconiosis.

Similarly, the January 30, 2001 x-ray was found positive by Dr. Cappiello, a dually certified reader. It was found negative by Dr. Castle, a B-reader, and by Drs. Wiot and Spitz, both of whom are dually certified. Once again, I turn to the numerical superiority of the negative readings. I am further persuaded by Dr. Wiot's finding this x-ray to be of top quality, while the other physicians found it to be "quality 2." For these reasons, I consider this film negative for pneumoconiosis.

The final x-ray, dated October 29, 2001, was unanimously found negative by those who read it: Drs. Castle, Wheeler, Scott, and Kim. There are no positive readings. I therefore find this x-ray to be negative for pneumoconiosis.

These constitute all of the x-ray interpretations in the record. The only x-rays I have found to be positive are the August 18, 1975, October 5, 1979, June 2, 1992 and July 11, 1995 films, none of which were reread. The two most recent of those were interpreted by a physician whose credentials are not of record. I have found all other x-rays, including the five most recent, to be negative. For this reason, and because the great majority of the most highly qualified readers found the x-rays negative, Mr. Adair cannot be found to have pneumoconiosis on the basis of the x-ray evidence.

My opinion is not altered by the CT scan results. Although an ALOSH physician interpreted the July 21, 1995 CT scan as revealing a small amount of black lung and some emphysema, Dr. Renn, a B-reader, reviewed the scan and found no changes consistent with pneumoconiosis. Because it is not clear from the record who the physician was who interpreted

the scan for ALOSH, I cannot determine his or her qualifications. Dr. Renn, on the other hand, is a B-reader and a pulmonary expert. I defer to his reading and consider the CT scan negative for pneumoconiosis.

I must next consider the medical opinions. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields,*above . Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149, 1-155 (1989) (en banc). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-1291, 1-1294 (1984). The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984).

While Dr. Hatfield diagnosed pneumoconiosis in 1980, his finding is based on an x-ray reading of 1/1 taken on the date he examined Mr. Adair, which reading is not in the file, and which has been re-read as negative by a dually qualified reader, Dr. Smith. Nor is there any indication in the record that the positive readings of x-rays taken in 1975 and 1979 were available to Dr. Hatfield. Dr. Hatfield found no rales or crackles on physical examination either. Thus, there appears to be no solid basis in objective data to support his finding. Accordingly, I do not consider Dr. Hatfield's report well documented or reasoned. As a result, I discount it. Furthermore, when I consider this report in relation to the more recent medical opinions of evidence, I find it is outweighed.

Of the physicians whose reports have been submitted in the duplicate claim, only Dr. Rasmussen diagnosed pneumoconiosis. He also said that tobacco smoking contributed to Mr. Adair's lung impairment. All remaining physicians–Drs. Castle, Rosenberg, Renn, and Morgan–agreed that smoking caused the impairment, and that Mr. Adair does not suffer from coal workers' pneumoconiosis. The latter opinions are supported by the x-ray evidence as a whole. The opinions of Drs. Castle, Rosenberg, and Renn are entitled to great probative weight because of their excellent credentials in the field of pulmonary disease. All four had the opportunity to review the medical evidence of record, thereby providing them with a broad base from which to draw their conclusions. Dr. Castle had the additional opportunity to examine Mr. Adair. Moreover, he cogently explained in his deposition why the pattern displayed by the pulmonary function studies do not support a finding of pneumoconiosis. Accordingly, I find the opinions of these physicians well documented and reasoned. Dr. Rasmussen's opinion is also well

documented and supported by the x-ray interpretation of Dr. Patel. It is, however, contrary to my finding regarding the August 2000 x-ray based on opposing interpretations. Furthermore, Dr. Rasmussen found no rales, rhonchi, or wheezing clinically. These physical findings are consistent with Dr. Castle's conclusion and fail to support Dr. Rasmussen's opinion. Because Dr. Rasmussen heavily relied upon a positive x-ray reading in making his determination and because his clinical findings do not substantiate that determination, I place less weight on his opinion. Rather, I find that the credible and well reasoned medical opinions of Drs. Castle, Rosenberg, Renn, and Morgan are convincing for purposes of establishing that the Claimant does not have pneumoconiosis. I conclude, therefore, that the weight of the medical opinions of record fails to establish that the Claimant has pneumoconiosis.

Causation of Total Disability

In order to be entitled to benefits, the Claimant must establish that pneumoconiosis is a "substantially contributing cause" to his disability. A "substantially contributing cause" is one which has a material adverse effect on the miner's respiratory or pulmonary condition, or one which materially worsens another respiratory or pulmonary impairment unrelated to coal mine employment. 20 CFR § 718.204(c) (2002); *Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 1990); *Robinson v. Pickands Mather & Co.*, 914 F.2d 35, 38 (4th Cir. 1990). As I have found that the evidence does not establish that Mr. Adair has pneumoconiosis, he cannot establish that pneumoconiosis is a substantial contributor to his disability.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Because the Claimant has failed to meet his burden to establish that he has pneumoconiosis, he is not entitled to benefits under the Act.

ATTORNEY FEES

The award of an attorney's fee under the Act is permitted only in cases in which the Claimant is found to be entitled to benefits. Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to him in pursuit of this claim.

ORDER

The claim for benefits filed by Woodrow Adair on May 31, 2000, is hereby DENIED.

A

Alice M. Craft
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 CFR § 725.481 (2002), any party dissatisfied with this decision and order may appeal it to the Benefits Review Board within 30 days from the date of this decision and order, by filing a notice of appeal with the Benefits Review Board at P.O. Box 37601, Washington, DC 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esq. Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Ave., NW, Washington, D.C. 20210.